Office of the State Auditor
Performance Audit Division

State of Mississippi

PHIL BRYANT
AUDITOR

A Performance Review of Mississippi's Chancery Court Processing of the Mentally Ill

January 11, 2000

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Phil Bryant
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STATE OF MISSISSIPPI

OFFICE OF THE STATE AUDITOR

PHIL BRYANT
AUDITOR

January 11, 2000

Dear Governor, Lieutenant Governor, Legislators, Public Officials and Citizens:

The Office of the State Auditor has completed, ***"A Performance Review of the Mississippi Chancery Court's Processing of the Mentally ILL"***.

The processing and commitment of the mentally ill by the chancery courts has been a concern to chancery judges, clerks, supervisors, sheriffs, legislators and the State Auditor's Office. This issue is rooted in concern for the patients and the sheriff's deputies, judges and attorneys, who are involved in the commitment process. Both from a safety and health prospective and an economical factor. Obviously, prevention of commitments and re-commitments can reduce the potential.

The purposes of this report are to gather both quantitative and antidotal information regarding chancery court commitments, exchange information among sources and to develop recommendations for the public, Governor, Legislature, Department of Mental Health and local government entities that will improve this process.

The recommendations included in this report were complied with the assistance from the Chancery Clerks Association, Mississippi Sheriff's Association, Mississippi Association of Supervisors and the Department of Mental Health. For their recommendations and counsel, we are grateful.

It is our hope the information gathered during this review and included herein will be of benefit to the principals involved in the chancery court commitment process, as well as the legislature and citizens of this state.

With best regards, I remain,

Sincerely,

Phil Bryant
State Auditor

PB/dm

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Division of Performance Audit

A Performance Review of Mississippi's Chancery Court Processing of the Mentally Ill

EXECUTIVE SUMMARY

January 11, 2000

Purpose of Review

Certain members of Boards of Supervisors in the State of Mississippi expressed concerns to the State Auditor in regard to mental health court operation in Mississippi. To address these concerns, the State Auditor of Mississippi initiated this performance review of mental health procedures in Mississippi to provide information and make recommendations for the public, Governor, Legislature, Department of Mental health, and local governmental entity officials.

The objectives of this review were to: 1)determine and analyze the various procedures for mental health court in Mississippi including initialization of proceedings, mental health hearings, and the processing of individuals deemed to need treatment, 2) determine and analyze the costs involved with mental health court proceedings by the state and local governments, 3) determine the available hospital (state facility and local) space for mental health patients and 4) determine possible solutions to problems identified during this project.

Scope

The scope of this review included reviewing current procedures and operations of mental health court in Mississippi at the state and local level. Field work for this review began in March 1999 and concluded in September 1999.

Report Summary

Chancery Court in Mississippi has as one of its functions the processing of individuals needing commitment to state facilities for mental health treatment. Local county governments have responsibility for operating the hearing and commitment process and the state, through the Department of Mental Health (DMH) has responsibility for the operation and maintenance of the state mental health facilities. This dual responsibility requires, for optimal operation and care, clear and effective communication between county governments and DMH.

The excessive waiting period between commitment and placement raises concerns over appropriate care for these individuals while awaiting state facility space. This care varies from county to county, with some counties providing extensive care and some

counties providing minimal care or no care at all. This points out an inherent weakness in care for the mentally ill in Mississippi. Based on county of residence, an individual while awaiting state hospital space, will be place in a holding center with appropriate care or placed in a jail cell or sent home without any medical care or monitoring. This period of time may be critical to the ultimate rehabilitation of mentally ill individuals.

There has been no consistent way to document, county by county, the amount of local support for mental health. DMH can report the amount counties fund regional mental health centers but counties incur much more than this individual cost. Court costs, costs of holding individuals and other costs related to the mental health commitment process are usually commingled with other budget items so counties are not able to report total funding commitment to mental health. Some sort of consistent cost reporting for mental health purposes is necessary in county governments. Without consistent reporting it will be difficult for the legislature to determine necessities in mental health areas.

DMH, while believing that counties should increase funding for local programs, acknowledges a need for increased state facilities space and has initiated a plan to meet this need. DMH has obtained legislative funding for additional facilities and has established long-range plans for other facilities not yet funded. Lists of funded facilities and of the non-funded facilities are included in this report.

Recommendations

(1) County officials should make an effort to identify their county's total funds committed to mental health. DMH should develop and distribute to counties a form for the purpose of identifying total county mental health commitments. Use of this form by counties would quantify the information consistently, thereby allowing a true comparison of individual county commitment to mental health. The form should include regional mental health contributions as well as other types of funds used for mental health purposes. Better decisions could be made concerning necessary legislation in mental health areas with such a consistent county to county reporting of mental health costs.

(2) County officials, through regional mental health centers, should develop or improve programs of preventive care and follow-up care. Such programs will reduce the burden on state facilities and reduce costs to the county over a period of time.

(3) DMH should continue their program of increasing state facilities such as the community based mental health crisis centers authorized by the 1999 legislature to provide state-wide comprehensive mental health services so individuals will have access to the least restrictive and appropriate level of services that will meet their needs.

Introduction

Purpose

Certain members of Boards of Supervisors in the State of Mississippi expressed concerns in regard to mental health court operation in Mississippi. To address these concerns, the State Auditor of Mississippi initiated this performance review of mental health procedures in Mississippi to provide information and make recommendations for the public, Governor, Legislature, Department of Mental Health, and local governmental entity officials.

The Auditor directed the Performance Audit Division (Division) to review and analyze the processes used in Mississippi Chancery Courts concerning mental health patients. The objectives of this review were to:

- determine and analyze the various procedures for mental health court in Mississippi including initialization of proceedings, mental health hearings, and the processing of individuals deemed to need treatment;
- determine and analyze the costs involved with mental health court proceedings by the state and local governments;
- determine the available hospital (state facility and local) space for mental health patients; and
- determine possible solutions to problems identified during this project.

Scope

The scope of this review is current procedures and operations of mental health court in Mississippi at the state and local level. Field work for this review began in March 1999 and concluded September 1999.

Method

In conducting this review, the Division performed the following procedures:

- interviewed selected local government and state employees;

- read appropriate statutory authority;
- prepared and mailed a survey questionnaire to Chancery Clerks to obtain information concerning mental health court operations in individual local governments; and
- analyzed Chancery Clerks' responses to mental health court questionnaire.

Report Summary

Chancery Court in Mississippi has as one of its functions the processing of individuals needing commitment to state facilities for mental health treatment. Local county governments have responsibility for operating the hearing and commitment process and the state, through the Department of Mental Health (DMH), has responsibility for the operation and maintenance of the state mental health facilities. This dual responsibility requires, for optimal operation and care, clear and effective communication between county governments and DMH.

County officials and DMH officials believe that the statutory process for committing individuals to mental health facilities is satisfactory. None of the individuals providing information for the purposes of this report made negative statements concerning the process of mental health commitment. However, almost unanimously, they expressed concern regarding the time required between commitment and placement of an individual ruled by mental health court to need help in a state hospital.

The excessive waiting period between commitment and placement raises concerns over appropriate care for these individuals while awaiting state facility space. This care varies from county to county, with some counties providing extensive care and some counties providing minimal care or no care at all. This points out an inherent weakness in care for the mentally ill in Mississippi. Based on county of residence, an individual while awaiting state hospital space, will be placed in a holding center with appropriate medical care or placed in a jail cell or sent home without any medical care or monitoring. This period of time may be critical to the ultimate rehabilitation of mentally ill individuals.

County governments and DMH have somewhat differing opinions of the main reason for the excessive waiting period. Counties tend to believe that the problem is simply a numbers problem or rather a serious lack of available beds in state facilities. Counties, for the most part, believe that increasing the number of beds in state facilities is a simple solution to the problem. DMH believes part of the problem is a tendency for counties to move local problems to the state by committing to state hospitals many individuals who should be helped locally through programs at regional mental health centers and local private programs. DMH also believes that counties should increase funding in support of regional mental health centers so more local programs can be made available.

DMH, while thinking that counties should increase funding for local programs, acknowledges a need for increased state facilities space and has begun a plan to meet this need. DMH has obtained legislative funding for additional facilities and has established long-range plans for other facilities not yet funded. Lists of the funded facilities and of the non-funded facilities are included in this report.

DMH believes that the ultimate operation of these new facilities combined with more county commitment to local mental health programs will resolve the problem of excessive waiting for mental health facilities.

There has been no consistent way to document, county by county, the amount of local support for mental health. DMH can report the amount counties fund regional mental health centers but counties incur much more than this individual cost. Court costs, costs of holding individuals and other costs related to the mental health commitment process are usually commingled with other budget items so counties are not able to report total funding commitment to mental health. Some sort of consistent cost reporting for mental health purposes is necessary in county governments. Without consistent reporting it will be difficult for the legislature to determine necessities in mental health areas.

Background

The treatment of the mentally ill in Mississippi is described statutorily in Section 41-21-61 through Section 41-21-107, Mississippi Code of 1972 Annotated. A "mentally ill person" is described in Section 41-21-61, (e) as follows:

> *any person who has a substantial psychiatric disorder of thought, mood, perception, orientation, or memory which grossly impairs judgment, behavior, capacity to recognize reality, or to reason or understand, which (i) is manifested by instances of grossly disturbed behavior or faulty perceptions; and (ii) poses a substantial likelihood of physical harm to himself or others as demonstrated by (A) a recent attempt or threat to physically harm himself or others, or (B) a failure to provide necessary food, clothing, shelter or medical care for himself, as a result of the impairment. This impairment does not include (1) epilepsy, (2) mental retardation, (3) brief periods of intoxication caused by alcohol or drugs, (4) dependence upon or addiction to any alcohol or drugs, or (5) senile dementia.*

A treatment facility is defined by Section 41-21-61, (i) as follows:

> *a hospital, community mental health center, or other institution qualified to provide care and treatment for mentally ill, mentally retarded, or chemically dependent persons.*

Section 41-21-63 states that no person, other than persons charged with crime, shall be committed

to a public treatment facility except under provisions of section 41-21-61 through 41-21-107. The chancery court or the chancellor in vacation has jurisdiction under these sections except over persons with unresolved criminal charges.

Various of these code sections establish the procedures involved in committing an individual to a public treatment facility. Brief summaries of some of these statutory authorities are in appendix A.

COUNTY GOVERNMENT

County Government Survey

The Division mailed a survey questionnaire, concerning mental health court procedures, to all (82) of the chancery clerks in Mississippi. The goal of this survey was to obtain input from these officials in their capacity as the clerk of the Chancery Court, the court of jurisdiction in civil mental health cases. The Division received responses from 79 chancery clerks accounting for 96 percent of the chancery clerks in Mississippi. All questions of the survey were not answered by all clerks resulting in analysis based on less than 100 percent response on certain questions. Results of the survey responses and our analysis are summarized below:

When a writ is issued for the sheriff to pick up a person allegedly needing treatment, where is the individual held to await a hearing?

There were 79 responses to this question. Of these responses **45 (57 percent) hold individuals at detention facilities, 14 (18 percent) use a medical facility and 8 (10 percent) allow individuals to wait at a residence while awaiting their hearing.** Twelve counties responded that they had same-day hearings which probably required some temporary holding at the courthouse.

These responses clearly indicate an inherent problem with the holding of individuals awaiting an admission hearing. Detention facility employees in counties in Mississippi are not qualified to provide necessary medical care needed by individuals while awaiting admission hearings. Days may pass before a hearing can be held for an individual causing frustration for the individual, his family and employees of the detention center. Detention centers are not considered ideal places for holding mentally disturbed individuals by anyone. However, they are used in many counties, 57 percent of the counties responding to the survey, because of lack of any other facility suitable for holding such individuals or budgetary restrictions. Generally, counties do not use medical facilities at this stage because of the cost involved. Fourteen (18 percent) of the responding counties indicated the use of a medical facility to hold individuals while awaiting their hearing. This points out a lack of consistent treatment for individuals in different counties in Mississippi, counties with more funds are able to furnish some medical care while other counties are forced to use their jails as holding facilities. Money is not the only factor as some counties with large tax basis have analyzed the cost

of holding such individuals in a medical facility and determined that the cost was too great and therefore used detention centers or residences.

This points out the inconsistent procedures used in various counties in Mississippi. Section 41-21-67 (4) of the Mississippi Code states the *[individual]* shall not be held in jail [*while awaiting an admission hearing*] unless the court finds that there is no reasonable alternative. The court has determined that there is no reasonable alternative in many counties.

Normally, how much time passes between the pick up of an individual by the sheriff and a commitment hearing?

There were 79 responses to this question. Of these responses **33 (42 percent) usually have hearings on the same day as pick-up. Thirty four (43 percent) have hearings within two or three days and 12 (15 percent) have hearings usually within four or more days.**

These various time frames for holding admission hearings, by themselves, do not present significant problems in processing individuals in mental health court. However, problems develop increasingly as the time between pick-up and admission hearing becomes longer. These problems result from the issues noted in the above question dealing with facilities used for holding individuals while awaiting their hearings. As noted above, 67 percent of survey responders stated that individuals were held either in detention centers or a residence while awaiting their hearing apparently without adequate medical care.

These problems result in inconsistent treatment of mentally disturbed individuals with adequate treatment depending on which county a person lives.

What type of doctors are used to evaluate individuals for determination of mental health?

Responders gave varying answers to this question, indicating that generally there is no problem in regard to the initial evaluation of individuals for mental problems. This refers to the appropriate and statutorily defined doctors who perform such evaluations and does not refer to the waiting periods or holding facilities mentioned above.

Where are individuals determined to need help placed while awaiting commitment to a state institution?

There were 75 responses to this question. Of these responses **33 (44 percent) mostly use detention centers, 21 (28 percent) mostly use a medical facility of some type and 21 (28 percent) mostly use personal residences while awaiting space at a state hospital.**

These responses point out the same type of inherent problems discussed above concerning holding of individuals while awaiting admission hearings. After court hearings decide that commitment is

necessary the individual, in an ideal situation, would be taken immediately to a state hospital or barring that to a medical facility of some type to await transfer to a state hospital. This is not the case because of various factors such as lack of available space at state facilities, lack of available space at other medical facilities or lack of funds to pay for temporary placement while awaiting space at a state hospital. **Responses to this question indicate that 72 percent of counties responding to this survey either place individuals needing commitment in a detention center or in a personal residence to await space at a state hospital.** This places individuals in situations where they probably do not receive the medical care they need. Family members are also placed in situations for which they have no training. They also may be placed in a dangerous situation depending on the mental state of the person awaiting state hospital space. Twenty eight percent of the responding counties indicated that most individuals are placed in a medical facility of some type where presumably they receive adequate medical care while they await transfer to a state facility.

These responses point out an inconsistency in the manner or treatment of an individual based on county of residence. Some counties are able to provide care while others do not placing individuals in jails or residences where needed care is difficult to obtain.

What type of jail facility does your county have for mental health patients?

There were 79 responses to this question. Of these responses **65 (82 percent) have only regular jail cells with no special consideration for mental patients. Fourteen (18 percent) indicated cells with special consideration for mental patients** such as a holding facility away from normal jail cells or padded cells. Responses indicating no jail facilities were considered part of the 65 having only regular jail cells for the purposes of this question which attempted to identify the types of jail facilities available for mental patients.

This response agrees with other questions indicating a lack of adequate medical care for individuals placed in a detention center cell awaiting transfer to a state hospital. Eighty two percent indicated no special consideration for mental patients and most of the fourteen indicating special cell considerations for mental patients did not indicate any adequate medical care. This is primarily a problem in the 44 percent of counties indicating that most of their mental patients are placed in detention centers while awaiting space at a state hospital. However, most counties eventually place some individuals in their detention centers when circumstances of a case require it.

What is the basis for decisions made as to the type facility an individual is placed for treatment while awaiting commitment to a state institution?

There were 76 responses to this question. Of these responses **40 (53 percent) indicated financial reasons as the main basis while 19 (25 percent) gave the degree of mental stability of the individual as the deciding factor in determining the type facility of placement. Seventeen (22 percent) said there was no financial consideration,** rather individuals were placed in jail, home or holding facility as a matter of policy.

The response to this question is another indicator of the inconsistent treatment of mentally ill individuals based on the county of residence. People with insurance or private funds can be placed in private hospitals while awaiting transfer to a state facility and other individuals are placed in detention centers or sent home. The individuals sent home or placed in a detention center probably do not receive appropriate medical care while awaiting state hospital space.

Normally, how much time passes before an individual, deemed to need help by a mental health court hearing, is moved to available space at a state institution?

There were 77 responses to this question. Of the responses **52 (68 percent) gave a time frame of two to five weeks for state hospital space to become available and 25 (32 percent) listed six weeks or more.** These time frames, by themselves, are not problematic, however when combined with the lack of adequate holding facilities or proper medical treatment as noted above a serious problem is shown.

An individual placed in a jail cell or a residence will not receive appropriate medical assistance and possibly could be more troubled when space becomes available. As shown above 32 percent of the responding counties stated that a minimum or six weeks pass before available space with some counties indicating much longer than six weeks. The problem, six or more weeks in a jail or at home without proper monitoring and treatment, is self evident and is accepted as a major problem by both local and state officials.

How much did your county spend on mental health court operation for fiscal year 98?

There were 70 responses to this question. **Thirty five (50 percent) indicated budgets of less than $10,000 with several of these showing $1,000 or less. Fourteen (20 percent)indicated budgets ranging from $10,001 to $30,000 and 21 (30 percent) indicated budgets over $30,000.** Some of the larger budgets were in the $200,000 to $300,000 range.

The responses to this question were inconsistent so these figures can not be considered totally accurate. There was not a common system of applying costs to a mental health court budget. Therefore, while these amounts may not be totally accurate they do give a picture of the range of local commitment to the mentally ill. Counties also may provide support for regional mental health centers.

Do you feel mental health patients receive appropriate care under the current system in your county?

There were 75 responses to this question. Of these responses **49 (65 percent) gave a negative response and 26 (35 percent) said appropriate care was received in their county.** Responses to this question were based only on the responders opinion and not on any official standard or definition of what constitutes appropriate care. However, this response does indicate that a majority

of counties do not feel that appropriate care is provided to the mentally ill.

Most of the responses indicated the primary cause of problems as the amount of time required before a state hospital bed becomes available for a person deemed to need commitment. During this waiting period individuals, in many cases, must wait at home or are placed in a detention center to await space in a state hospital. During this waiting period the individual, in many cases, does not receive necessary care.

Cost to County Governments

As shown, county governments budget for mental health court operations varies greatly from county to county. Mental health court budgets ranged from $1,000 annually to budgets in the hundreds of thousands. While responses to this survey appeared inconsistent in allocation of costs to mental health courts there is a clear pattern of differing commitment to the mentally ill in various counties. The primary contributor to these differences is the cost of housing individuals committed while awaiting space at a state facility. Counties that provide holding facilities or pay for private hospital space obviously spend much more than counties that simply place individuals in jail cells or send them home to await space. These counties with the higher costs also provide the better care for individuals compared to counties with lower budgets who actually provide no care.

County governments may contribute to regional mental health centers as authorized by Section 41-19-31 of the Mississippi Code. Section 41-19-39 authorizes the county Board of Supervisors to use any available funds and if necessary to levy a tax, not to exceed two mills, for the construction, operation and maintenance of mental illness and mental retardation facilities or services provided for and authorized in 41-19-31 to 41-19-39. This does not limit the amount of funds a county may contribute but does limit the imposition a new tax levy for such support to two mills.

Also, the governing authority of any municipality in the region may make a voluntary contribution for the construction, operation or maintenance of the mental illness and mental retardation facilities in the region where the municipality lies.

The above statutes authorize county support but does not require such support. However, the appropriation bill of the Department of Mental Health annually requires that local contribution to regional mental health facilities met a certain level before the DMH may contribute money. This minimum contribution by local boards of supervisors is the **greater** amount of proceeds of a .75 mill levied on 1982 taxes or the amount actually contributed by a county in 1984.

Appendix B is from information furnished by DMH and gives information on local tax funds by county for regional mental health facilities.

Information in Appendix B gives funds allocated by counties for regional mental health centers. The appendix does not include any other county costs supporting mental health such as county funded

holding centers, court costs, costs of sheriff's office and other type costs supporting the mental health process. Accurate information on total funds committed to mental health on a county by county basis was not available. Answers to our survey questionnaire indicated that there is a wide range of commitment to the mentally ill, ranging from significant commitment to minimal commitment. Appendix B shows that while counties are supporting regional mental health facilities, in most cases, more than the minimum amount required by DMH, counties are providing significantly less than the 2 mills maximum allowed by law.

There appears to be a need for some type of consistent support for the treatment of mentally ill individuals from county to county. An inherent issue of fairness needs to be addressed when the level of commitment to mental health varies significantly from county to county. Currently, there is no acceptable method to verify total commitment to mental health. County officials should make an effort to identify their county's total funds committed to mental health. DMH should develop and distribute to counties a form for the purpose of identifying total county mental health commitment. Use of this form by counties would quantify the information consistently, thereby allowing a true comparison of individual county commitment to mental health. The form should include regional mental health contributions as well as other types of funds used for mental health purposes. Better decisions could be made concerning necessary legislation in mental health areas with such a consistent county to county reporting of mental health costs.

Prevention and Follow-up Care

Prevention programs and follow-up care programs are inconsistent from county to county. Regional or county programs designed to help individuals with mental problems without the necessity of processing through the court system will help ease backlogs of individuals awaiting rooms at a state facility. Also, regional or county programs designed to provide follow-up care for individuals discharged from state hospital facilities will help the problem of individuals who require numerous commitments to mental institutions. The simple task of following up to determine that an individual continues to take required medication will solve many problems. The Division was told of many instances where individuals were committed to state institutions and given a treatment plan of medication. The individual's problems improved with medication and they were discharged from the state institution. The individual then neglected taking necessary medication and mental problems returned necessitating another trip through the court process and possible more time committed to a state mental facility.

County officials, through regional mental health centers, should develop or improve programs of preventive care and follow-up care. Such programs will reduce the burden on the state facilities and reduce costs to the county over a period of time.

STATE DEPARTMENT OF MENTAL HEALTH

The State Department of Mental Health was created in 1974 placing in one agency mental health, alcohol/drug abuse and mental retardation programs. These programs had previously been under the direction of the State Board of Health, the Interagency Commission on Mental Illness and Retardation, the Board of Trustees of Mental Institutions and the Governor's Office. Statutory authority for the Department of Mental Health is found in the Mississippi Code 41-4-1 through 41-4-23.

Section 41-4-1 defines the purpose of the Department of Mental Health as follows:

> *The purpose of this chapter is to coordinate, develop, improve, plan for, and provide all services for the mentally ill, emotionally disturbed, alcoholic, drug dependent, and mentally retarded persons of this state; to promote, safeguard and protect human dignity, social well-being and general welfare of these persons under the cohesive control of one (1) coordinating and responsible agency so that mental health and mental retardation services and facilities may be uniformly provided more efficiently and economically to any resident of the state of Mississippi; and further to seek means for the prevention of these disabilities.*

Section 41-4-3 creates a state board of mental health (Board). The Board consist of nine members appointed by the Governor with the consent of the Senate. One person shall be appointed from each congressional district and four shall be appointed from the state-at-large. The at-large appointments shall include one licensed medical doctor who is a psychiatrist, one of whom shall hold a Ph.D. and be a licensed clinical psychologist, one of whom shall be a licensed medical doctor and one whom shall be a social worker with experience in the mental health field. Board members serve staggered seven year terms.

Section 41-4-7 lists the powers and duties of the Board which includes setting up state plans for the purposes of controlling and treating any and all forms of mental illness, and supervising coordinating and establishing standards for all operations and activities of the state related to mental health and providing mental health services. The Board also certifies, coordinates and establishes minimum standards and establishes minimum required services for regional mental health commissions and other community service providers for community or regional programs and services in mental health and related programs throughout the state. Appendix B is a listing of powers and duties of the Board.

All new programs authorized under this section shall be subject to the availability of funds appropriated by the Legislature.

The philosophy of the Department of Mental Health as taken from their web page follows:

The Department of Mental Health is committed to developing and maintaining a comprehensive, statewide system of prevention and service options for adults and children with mental illness or emotional disturbance, with alcohol/drug abuse problems, and/or with mental retardation or developmental disabilities. This array of services includes prevention, treatment, and training services in inpatient or institutional settings, as well as a system of community based treatment, residential, and support services that include transitional and aftercare programs.

The department supports the philosophy of making available a comprehensive system of services so that individual consumers and their families have access to the least restrictive and appropriate level of services that will meet their needs. The seven [ten] regional facilities operated by the Department of Mental Health, the fifteen regional community mental health/mental retardation centers, and other nonprofit agencies that receive funding through the department form a statewide network of public services and support systems. Consistent with its philosophy, the department strives to maintain high standards and to continually improve the availability, accessibility, and quality of services provided through this public system.

A priority of the department is to work with individual consumers and their families to develop the capacity of communities, so that needed services and supports can be offered locally. The department has attempted to do this by developing an array of community programs that will provide services to individuals as close to their homes and communities as possible. The department also hopes to prevent or reduce unnecessary use of inpatient or institutional services when individual needs can be met in less intensive or restrictive levels of care.

The department also works to provide accessible inpatient and institutional services as part of the comprehensive statewide service network for individuals who need services of this nature and intensity. Therefore, efforts to maintain and improve the quality of services provided at the two [four] psychiatric hospitals and five [six] regional facilities for persons with developmental disabilities are ongoing. Underlying these efforts in both community and inpatient or residential services is the belief that all components of the system should be consumer-centered and built on individuals' and their families' strengths, while also meeting their needs for special services.

Finally, in accomplishing its mission of developing an accessible, comprehensive service system for individuals with mental illness, alcohol/drug abuse problems, and/or mental retardation/developmental disabilities, the Department of Mental Health is committed to its obligation to efficiently administer its human and fiscal resources, as well as to identify and communicate existing needs and advocate for resources to meet those needs.

Numbers in brackets indicate new facilities that are not currently reflected in DMH's web page.

Additions to State Mental Health Facilities

The executive director of DMH stated, "It is the Department of Mental Health's goal that every citizen in our state with mental illness, mental retardation or substance abuse be able to access appropriate, quality services within driving distance from his or her hometown. When the new facilities are all completed and open for operation, and the future plans outlined by the Department are able to be implemented, the waiting list for these services should be greatly reduced and hopefully, even eliminated altogether."

DMH begins, with the legislative process necessary to approve new facilities, to inform the public of the subsequent availability of new mental health facilities by meeting with members of the legislature including members from the area of service of the new facility. New facilities are further publicized during the legal advertisement process. Meetings are held by DMH representatives with local officials such as mayors, boards of supervisors and other appropriate officials. Meetings are also held with local economic development groups and various civic clubs. Open hearings are held for local individuals to discuss the new facilities and individual inquiries are answered as required. A ceremonial public groundbreaking is normally held which provides additional publicity for the new facility. While DMH does not have any formal policy for notifying local officials of future new facilities the steps listed above appear entirely adequate to notify local officials of new mental health facilities in their areas.

DMH indicated that progress has been made in reducing the waiting period for obtaining state facility space. Funding has been provided by the legislature to construct or improve the following facilities.

North Mississippi State Hospital - This facility, a fifty bed acute care facility located in Tupelo, opened in April, 1999 serving Regions 2, 3 and 4. Patients needing extended treatment are transferred to Mississippi State Hospital. Construction costs for this facility were stated by DMH as $7,900,000 and the annual operating budget was shown as $6,750,000.

South Mississippi State Hospital - This facility, a fifty bed acute care psychiatric hospital is under construction in Purvis and is scheduled to be opened in February, 2000. Construction costs for this facility were stated by DMH as $7,900,000 and the annual operating budget was shown as $6,750,000.

Juvenile Rehabilitation Center - Harrison County - Land has been acquired but construction has not yet begun on this facility. It will serve adolescents who meet commitment criteria for mental illness who are involved with the criminal justice system. Construction costs for this facility were stated by DMH as $7,900,000 and

the annual operating budget was shown as $6,240,000.

Central Mississippi Residential Center - Newton - This facility is currently being renovated to provide a specialized residential treatment program for adults with long-term serious mental illness who have been discharged or transferred from a state hospital. This facility has a projected bed capacity of approximately 150 beds with an anticipated completion date of fall 2000. Construction costs for this facility were stated by DMH as $9,000,000 and the annual operating budget was shown as $12,250,000.

Adolescent Unit - East Mississippi State Hospital - Bonds will soon be issued for the construction of a new 50 bed facility to be located near the East Mississippi State Hospital campus. This facility will replace the adolescent unit now located on the East Mississippi State Hospital campus and will serve as an acute psychiatric hospital for adolescents in the East Mississippi State Hospital area. Construction costs for this facility were stated by DMH as $11,850,000 and the annual operating budget was shown as $3,376,000.

Seven 17 Bed Crisis Centers - Through a bonding bill, DMH has been funded to construct seven crisis centers for person with mental illness. These centers will serve persons who seek voluntary treatment or civil commitment. These crisis centers will be located in Corinth, Batesville, Brookhaven, Cleveland, Grenada, Newton and Laurel. Construction costs for these facilities were stated by DMH as $2,500,000 each or $17,500,000 total. The annual operating budget was shown by DMH as $1,950,000 each or $13,650,000 total.

The completion and use of these facilities will help with the backlog of individuals needing treatment at a state facility. However, DMH realizes long-term planning is necessary and has developed a listing of future mental health needs. These needs have not yet been funded by the state legislature. The future needs list includes the following mental health facilities.

Future Needs List

Alcohol and Drug Facilities - DMH will be requesting funding for two additional facilities to serve persons with addiction to alcohol and/or drugs. These new facilities would be adjunct facilities of North Mississippi State Hospital and South Mississippi State Hospital. DMH estimates construction cost for these facilities to be $5,100,000 each or $10,200,000 total and the estimated annual operating budget is $5,450,000 each or $10,900,000 total.

Crisis Centers - DMH will request funding for an additional eight crisis intervention centers. These centers along with the seven centers previously funded will create a

crisis intervention center for each of the 15 community mental health center districts. DMH estimates the construction costs for these facilities will be $2,500,000 each or $20,000,000 total. DMH estimates the annual operating budget will be $1,950,000 each or $15,600,000 total.

Long-term Care Adolescent Unit - DMH will be requesting funding for a 60 bed long-term adolescent unit to be located at East Mississippi State Hospital. DMH estimates the construction costs of this facility will be $18,000,000 with an estimated annual operating budget of $11,750,000.

DMH should continue their program of increasing state facilities such as the community based mental health crisis centers authorized by the 1999 legislature to provide state-wide comprehensive mental health services so individuals will have access to the least restrictive and appropriate level of services that will meet their needs.

Conclusion

There is a general consensus in Mississippi, among the officials and offices involved in the mental health court process, that the statutory authority is sufficient. None of the individuals providing information for the purposes of this report gave negative statements concerning the process of mental health commitment. However, there was almost a unanimous concern with the time required for an individual, ruled by mental health court to need help, between commitment and placement in a state hospital. Concerns over the care of individuals during this waiting period appear valid. Levels of treatment range greatly from county to county with some counties placing individuals in holding facilities with basically adequate treatment and other counties either sending individuals home to await state hospital space or placing the person in a local jail facility with limited or no medical treatment.

Survey questionnaires mailed to all chancery clerks showed a time frame of generally two to six weeks between the time of commitment to obtaining space at a state hospital. As mentioned above, some of these individuals may receive appropriate care while awaiting hospital space while many receive minimal care or no care.

The differing levels of care from county to county is an issue of basic fairness. Is it right for a person to receive appropriate care based strictly on which county he lives, receiving adequate care in county "A" while receiving absolutely no care in county "B"? The type of care is not an issue in this report but rather the policies dealing with the implementation and time frames of providing care.

Funding, obviously, is the primary factor in the differing degrees of care from county to county. As mentioned earlier in this report, budgeted funds for supporting mental health proceedings range from less than $1,000 annually to hundreds of thousand annually. This is in addition to support of regional

mental health centers where most counties provide more than the minimum required but far less than the maximum tax levy authorized would produce. Survey questionnaire responses indicated , as common sense dictates, that counties with higher budgets usually provide better care while counties with lower budgets provide minimal or no care. County budgets are sometimes dependent on the degree of care mandated by court order. Some chancellors require holding centers while some do not, again an indicator of inconsistent treatment of mentally ill individuals. Most survey responses indicated an acknowledgment of problems with treatment of mentally ill individuals but consistently indicated problems with available funds or liability issues in providing adequate care for these people. Most county officials felt than an increase in the number of state hospital beds for mental ill committees would solve the problem of providing adequate care for these individuals.

The State Department of Mental Health (DMH) controls state facilities for mentally ill persons. DMH is aware that problems exist with time required to obtain state hospital space, however they are limited to funds appropriated by the legislature in developing solutions. DMH has received authority from the Mississippi legislature to construct several new mental health facilities which should help with the waiting period. DMH has made significant progress in this area. This report lists the facilities that have had funding approved by the legislature and future needs as determined by DMH not yet funded by the legislature.

RECOMMENDATIONS

Recommendations

1. County officials should make an effort to identify their county's total funds committed to mental health. DMH should develop and distribute to counties a form for the purpose of identifying total county mental health commitment. Use of this form by counties would quantify the information consistently, thereby allowing a true comparison of individual county commitment to mental health. The form should include regional mental health contributions as well as other types of funds used for mental health purposes. Better decisions could be made concerning necessary legislation in mental health areas with such a consistent county to county reporting of mental health costs.

2. County officials, through regional mental health centers, should develop or improve programs of preventive care and follow-up care. Such programs will reduce the burden on state facilities and reduce costs to the county over a period of time.

3. DMH should continue their program of increasing state facilities such as the community based mental health crisis centers authorized by the 1999 legislature to provide state-wide comprehensive mental health services so individuals will have access to the least restrictive and appropriate level of services that will meet their needs.

APPENDICES

Appendix A

Procedures involved in Committing an Individual to a Public Treatment Facility

Section 41-21-65:

Any relative of a person alleged to need treatment or any interested person, defined by statute, may make affidavit and file such affidavit with the chancery clerk. The affidavit must contain descriptions of the proposed patient's recent behavior indicating need for treatment.

Section 41-21-67:

When affidavit is filed with chancery clerk, the clerk, upon direction of the chancellor of the court, shall issue a writ to the sheriff to take into custody the person alleged to need treatment. The chancellor shall appoint two licensed physicians or one such physician and a psychologist to conduct a physical and mental evaluation of the person and report their findings to the chancery clerk or chancellor. The chancellor shall appoint an attorney to represent the person if the individual does not have an attorney. If the chancellor determines there is probable cause to believe the person is mentally ill, the chancellor may order the person retained as an emergency patient at any available regional mental health facility or any other available suitable location as the court may so designate pending an admission hearing. Any person so retained **may be given** standard medical treatment by a licensed physician. The person shall not be held in a hospital operated directly by the Department of Mental Health and shall not be held in jail unless the court finds that there is no reasonable alternative.

Section 41-21-73:

The admission hearing shall be conducted before the chancellor. The person deemed to need treatment must be present at the hearing unless the chancellor determines the person is unable to attend and makes that part of the record. If evidence indicates the person is mentally ill and the court finds that there is no suitable alternative to commitment, the court shall commit the patient for treatment in the least restrictive treatment facility that can meet the patient's treatment needs. The initial commitment shall not exceed three months.

Section 41-21-77:

If hearing orders admission to a treatment facility, the sheriff or any other person authorized by the court shall immediately deliver the patient to the director of the appropriate institution. However, no person shall be delivered or admitted until the director of the admitting institution determines that facilities and services are available.

Section 41-21-79:

The costs of the court proceedings shall be paid out of the funds of the county of residence of the respondent when the patient is indigent unless funds for such purposes are made available by the state. If the respondent is not indigent the costs shall be charged against the respondent or his estate. If the respondent is found to not be in need of mental treatment, then costs shall be taxed to the person initiating the hearing.

Various of these code sections establish the procedures involved in providing continuing treatment for a patient committed to a public treatment facility. Brief summaries of some of these statutory authorities follows:

Section 41-21-81:

If at any time within twenty days after admission of a patient to a treatment facility the director determines the patients is in need of continued hospitalization, he shall give written notice of his findings to the respondent, the patient's attorney, the clerk of the admitting court and the two nearest relatives or guardian of the patient. The patient or any aggrieved relative or friend or guardian shall have 60 days to request a hearing on the question of the need of continued treatment.

Section 41-21-82:

Prior to the termination of the initial commitment order, the director of the facility shall cause an impartial evaluation of the patient to assess the extent to which the grounds for the initial commitment continues. If, after reviewing the director's report, the court finds that the patient continues to be mentally ill, the commitment may be continued.

Section 41-21-87:

The director of a treatment facility may:

(1) discharge any civilly committed patient upon filing his certificate of discharge with the clerk of the committing court, certifying that the patient, in his judgment, does not posses a substantial threat of physical harm to himself

or others.

(2) return any patient to the custody of the committing court upon providing seven days notice and certifying that, a) in the judgment of the director, the patient may be treated in a less restrictive environment, or b) in the judgment of the director, adequate facilities or treatment are not available at the treatment facility.

Section 41-21-99:

The director or a physician on the staff of the treatment facility shall, not less frequently than every six months, examine the patient and review the records to determine the need for continued treatment of each patient.

Appendix B

Local Tax Funds Used for Regional Mental Health Facilities

County Local Tax Funds - Regional Mental Health Facilities						
Region	County	.75 Mill in 1982	Actual Contribution 1984	Minimum Required	Actual 1999 Contribution	Estimated Proceeds of 2 Mill Levy
1	Coahoma	$63,364	$49,500	$63,364	$63,364	$183,109
1	Quitman	19,000	21,500	21,500	25,200	60,092
1	Tallahatchie	18,700	17,357	18,700	18,700	84,909
1	Tunica	14,825	14,113	14,825	40,000	107,789
2	Calhoun	17,446	16,900	17,446	21,645	83,386
2	DeSoto	81,496	86,157	86,157	162,225	664,614
2	Lafayette	25,800	35,450	35,450	46,750	181,091
2	Marshall	26,000	24,505	26,000	36,750	148,368
2	Panola	30,000	30,000	30,000	39,000	172,903
2	Tate	22,000	20,000	22,000	24,000	124,024
2	Yalobusha	12,000	12,000	12,000	16,200	61,735
3	Benton	8,383	8,556	8,556	9,668	39,870
3	Chickasaw	23,997	22,383	23,997	29,380	103,852
3	Itawamba	14,712	16,787	16,787	16,787	99,789
3	Lee	82,254	88,508	88,508	93,810	610,966
3	Monroe	35,982	41,739	41,739	46,000	244,758
3	Pontotoc	24,491	24,493	24,493	29,380	137,109
3	Union	20,661	21,892	21,892	26,000	135,787
4	Alcorn	27,621	39,298	39,298	43,227	212,153
4	Prentiss	17,011	26,000	26,000	36,000	101,794

County Local Tax Funds - Regional Mental Health Facilities						
Region	County	.75 Mill in 1982	Actual Contribution 1984	Minimum Required	Actual 1999 Contribution	Estimated Proceeds of 2 Mill Levy
4	Tippah	17,311	25,433	25,433	45,000	101,575
4	Tishomingo	18,000	26,000	26,000	26,400	128,531
5	Bolivar	72,469	186,657	186,657	253,400	256,514
5	Issaquena	9,375	10,000	10,000	15,000	27,237
5	Sharkey	11,250	31,000	31,000	49,000	51,756
5	Washington	165,375	297,500	297,500	345,000	459,970
6	Attala	27,740	30,924	30,924	46,200	135,377
6	Carroll	15,161	15,799	15,799	25,000	63,507
6	Grenada	28,084	30,000	30,000	35,881	150,566
6	Holmes	23,900	25,017	25,017	26,800	110,601
6	Humphreys	16,600	19,900	19,900	28,496	71,874
6	Leflore	68,749	98,790	98,790	123,522	224,671
6	Montgomery	15,462	17,073	17,073	22,598	62,168
6	Sunflower	57,066	57,300	57,300	57,300	172,874
7	Choctaw	10,000	14,000	14,000	14,000	48,326
7	Clay	20,000	20,000	20,000	24,000	136,764
7	Lowndes	71,250	60,827	71,250	81,717	442,662
7	Noxubee	15,599	15,000	15,599	20,900	69,706
7	Oktibbeha	36,000	38,250	38,250	41,310	212,409
7	Webster	14,967	9,100	14,967	15,166	60,810
7	Winston	13,000	14,500	14,500	19,500	118,930
8	Copiah	30,000	0	30,000	65,000	143,656
8	Madison	56,400	57,417	57,417	109,800	576,560

County Local Tax Funds - Regional Mental Health Facilities						
Region	County	.75 Mill in 1982	Actual Contribution 1984	Minimum Required	Actual 1999 Contribution	Estimated Proceeds of 2 Mill Levy
8	Rankin	111,334	120,000	120,000	185,000	740,766
8	Simpson	25,000	28,125	28,125	35,695	140,601
9	Hinds	521,377	500,000	521,377	722,050	1,999,413
10	Clarke	23,612	26,012	26,012	26,000	125,185
10	Jasper	22,003	23,245	23,245	25,174	106,537
10	Kemper	15,403	20,101	20,101	20,538	53,797
10	Lauderdale	124,632	139,354	139,354	152,283	556,383
10	Leake	16,068	18,133	18,133	18,200	99,200
10	Neshoba	19,861	19,236	19,861	21,339	127,341
10	Newton	21,093	28,712	28,712	29,500	116,404
10	Scott	26,341	28,978	28,978	31,000	145,880
10	Smith	20,840	20,339	20,840	20,840	93,936
11	Adams	77,143	73,700	77,143	77,000	273,397
11	Amite	18,000	20,250	20,250	23,625	135,278
11	Claiborne	17,022	18,162	18,162	21,600	73,797
11	Franklin	12,135	15,106	15,106	17,850	59,687
11	Jefferson	13,000	14,000	14,000	18,050	45,857
11	Lawrence	22,500	22,500	22,500	22,500	118,044
11	Lincoln	28,500	28,745	28,745	32,775	200,351
11	Pike	49,000	48,000	49,000	69,450	222,406
11	Walthall	17,000	17,000	17,000	17,850	90,554
11	Wilkinson	13,751	15,302	15,302	16,875	65,946
12	Covington	26,208	28,500	28,500	35,500	132,944

County Local Tax Funds - Regional Mental Health Facilities						
Region	County	.75 Mill in 1982	Actual Contribution 1984	Minimum Required	Actual 1999 Contribution	Estimated Proceeds of 2 Mill Levy
12	Forrest	117,308	130,000	130,000	212,500	467,011
12	Greene	11,928	12,250	12,250	26,000	52,157
12	Jefferson Davis	15,155	18,887	18,887	28,000	87,010
12	Jones	102,418	102,418	102,418	145,000	365,641
12	Lamar	28,974	30,000	30,000	70,000	224,716
12	Marion	42,254	45,000	45,000	60,000	149,995
12	Perry	13,800	19,500	19,500	26,112	71,258
12	Wayne	16,607	25,140	25,140	45,000	117,423
13	Hancock	35,841	89,447	89,447	100,000	310,298
13	Harrison	194,583	484,089	484,089	695,000	1,497,489
13	Pearl River	41,576	51,654	51,654	86,000	230,256
13	Stone	12,750	17,000	17,000	27,500	66,062
14	George	17,000	34,400	34,400	53,000	90,591
14	Jackson	228,000	285,000	285,000	422,080	1,073,377
15	Warren	118,889	127,000	127,000	157,000	527,719
15	Yazoo	45,000	46,500	46,500	50,100	169,835

Source: State Department of Mental Health

Appendix C

Statutory Powers and Duties of the State Board of Mental Health

1. Appoint a full-time executive director of the Department of Mental Health.

2. Set up state plans for the purposes of controlling and treating any and all forms of mental and emotional illness, alcoholism , drug misuse and developmental disabilities.

3. Supervise, coordinate and establish standards for all operations and activities of the state related to mental health and providing mental health services.

4. Enter into contracts with any other state or federal agency, or with any private person, organization or group capable of contracting.

5. Collect reasonable fees for its services.

6. Certify, coordinate and establish minimum standards and establish minimum required services for regional mental health and mental retardation commissions and other community service providers for community or regional programs and services in mental health, mental retardation, alcoholism, drug misuse, developmental disabilities, compulsive gambling, addictive disorders and related programs throughout the state.

7. Establish and promulgate reasonable minimum standards for the construction and operation of state and all Department of Mental Health certified facilities.

8. Assist community or regional programs by making grants and contracts from available funds.

9. Establish and collect reasonable fees for necessary inspection services incidental to certification or compliance.

10. Accept gifts, trusts, bequests, grants, endowments or transfers of property of any kind.

11. Receive monies coming to it by way of fees for services or by appropriations.

12. Serve as the single state agency in receiving and administering any and all funds available from any source for the purpose of service delivery, training, research and education in regard to all forms of mental illness, mental retardation, alcoholism, drug misuse and developmental disabilities, unless such funds are specifically designated to a particular agency or institution by the federal government, the Mississippi

Legislature or any other grantor.

13. Establish mental health holding centers for the purpose of providing short-term emergency mental health treatment, places for holding persons awaiting commitment proceedings or awaiting placement in a state mental health facility following commitment, and for diverting placement in a state mental health facility.

14. Certify/license case managers, mental health therapists, mental retardation therapists, mental health/retardation program administrators, addiction counselors and others as deemed appropriate by the board.

15. Develop formal mental health worker qualifications for regional metal health and mental retardation commissions and other community service providers.

16. Employees of the department shall be governed by personnel merit system rules and regulations, the same as other employees in state services.

17. Establish rules and regulations as may be necessary in carrying out the provisions of this chapter, including the establishment of a formal grievance procedure to investigate and attempt to resolve consumer complaints.

18. Grant easements for roads, utilities and any other purpose it finds to be in the public interest.

19. Survey statutory designations, building markers and the names given to mental health/retardation facilities and proceedings in order to recommend deletion of obsolete and offensive terminology relative the mental health/retardation system.

20. Ensure an effective case management system directed at persons who have been discharged from state and private psychiatric hospitals to ensure their continued well-being in the community.

21. Develop formal service delivery standards designed to measure the quality of services delivered to community clients.

22. Establish regional state offices to provide mental health crisis intervention centers and services available throughout the state to be utilized on a case-by-case emergency basis.

23. Require performance contracts with community mental health/mental retardation service providers to contain performance indicators to measure successful outcomes.

24. Enter into interagency agreements with other state agencies, school districts and other local entities as determined necessary by the department to ensure that local mental

health service entities are fulfilling their responsibilities to the overall state plan for behavioral services.

25. Establish and maintain a toll-free grievance reporting telephone system for the receipt and referral for investigation of all complaints by clients of state and community mental health/retardation facilities.

26. Establish a peer review/quality assurance evaluation system that assures that appropriate assessment diagnosis and treatment is provided according to established professional criteria and guidelines.

27. Develop and implement state plans for the purpose of assisting with the care and treatment of persons with Alzheimer's disease and other dementia.